IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF NEBRASKA

PAUL BOROVAC Plaintiff, v. NATIONAL RAILROAD PASSENGER CORPORATION, d/b/a AMTRAK, and CONEXIS BENEFITS ADMINISTRATORS, LP, Defendants.	CASE NO. 14-361 **COMPLAINT**

Plaintiff, Paul Borovac, states the following as his cause of action:

1. This is an action under the Employee Retirement Income Security Act (hereinafter referred to as "ERISA"), 29 U.S.C. § 1001 et seq., and the Consolidated Omnibus Budget Reconciliation Act (hereinafter referred to as "COBRA"), 29 U.S.C. § 1161 et seq., which arises from Defendants' failure to provide notice to Plaintiff of his right to elect coverage under the aforementioned statutes.
2. Plaintiff Paul Borovac is a resident of Council Bluffs, Pottawattamie County, Iowa.
3. Defendant National Railroad Passenger Corporation (hereinafter referred to as "Amtrak") is a foreign corporation incorporated in Washington, D.C., but is authorized and does transact business in Omaha, Douglas County, Nebraska.
4. At all times material to the present action, Amtrak was doing business at 1003 South 9th Street, Omaha, NE 68108.
5. Defendant Conexis is a West Virginia limited partnership doing business at 6190 North State Highway 161 Suite 200, Irving, Texas 75062.

6. Defendant Conexis was contracted by Defendant Amtrak as plan administrator to send notice to terminated employees of Amtrak of termination of their health coverage and the ability to elect coverage under COBRA.

VENUE

7. The acts which form the basis of Plaintiff's Complaint occurred in Douglas County, Nebraska and Pottawattamie County, Iowa.

STATEMENT OF JURISDICTION

8. Jurisdiction is appropriate, pursuant to 28 U.S.C. §1331, because the claims arise under the law of the United States.

9. Jurisdiction is appropriate over state courts because the claims are brought under ERISA §502(c)(1) to enforce late-notice penalties. *Johnson v. Colonial Life & Accident Ins. Co.*, 173 N.C. App. 365 (2005).

FACTUAL BACKGROUND

10. Plaintiff repleads paragraphs 1 through 9 as if fully set forth herein.

11. Plaintiff was hired by Defendant Amtrak on September 12, 2006.

12. Plaintiff was fired by Defendant Amtrak on October 11, 2013.

13. The attached Exhibit 1 is a true and accurate copy of the notice of termination Plaintiff received on October 11, 2013.

14. On October 11, 2013, Plaintiff's mailing address was P.O. Box 1983, Council Bluffs, IA 51502.

15. On October 11, 2013, Defendant Amtrak had knowledge of Plaintiff's mailing address. See Exhibit 1.

16. Plaintiff did not receive notice of his option to elect continued coverage under COBRA via a letter from Conexis dated June 16, 2014.

17. Exhibit 2 is a true and accurate copy of the correspondence Plaintiff received from Conexis.

18. Plaintiff did elect continuing coverage under COBRA for health and vision insurance on July 25, 2014.

19. Exhibit 3 is a true and accurate copy of the executed COBRA Continuation Coverage Election Form Plaintiff sent to Conexis on July 25, 2014.

20. Following his termination on October 11, 2013, but prior to his election to receive COBRA benefits on July 25, 2014, Plaintiff sought and received medical care.

21. Plaintiff has directly paid or arranged to directly pay for the healthcare treatment he received between October 11, 2013, and July 25, 2014.

22. Plaintiff has directly paid or arranged to directly pay over $895.50 for the healthcare treatment he received between October 11, 2013, and July 25, 2014.

COUNT I

DEFENDANT AMTRAK'S VIOLATION OF ERISA AND COBRA

23. Plaintiff repleads paragraphs 1 through 22 as if fully set forth herein.

24. Defendant Amtrak is and was at all times material an "employer" within the meaning of ERISA and COBRA.

25. Plaintiff is and was at all times material a "participant" and "beneficiary" within the meaning of ERISA and COBRA.

26. Defendant Amtrak failed to notify the administrator, Defendant Conexis, within 30 days of the qualifying event of the termination of Plaintiff's employment, as is required by U.S.C. § 1166, and did not notify Conexis until May 1, 2014 at the earliest.

27. As a result of Defendant Amtrak's acts and omissions, Plaintiff has suffered prejudice in the form of incurring medical expenses not covered by health insurance.

COUNT II

DEFENDANT CONEXIS'S VIOLATION OF ERISA AND COBRA

28. Plaintiff repleads paragraphs 1 through 27 as if fully set forth herein.

29. Defendant Conexis is and was at all times material an "administrator" within the meaning of ERISA and COBRA.

30. Defendant Conexis failed to notify Plaintiff within 14 days of employer Defendant Amtrak communicating to Conexis the qualifying event of Plaintiff's termination of employment, as is required by 29 U.S.C. § 1166.

Plaintiff respectfully requests this Court enter judgment in his favor and against Defendants and awards the following relief:

A. $22,770.00 in statutory penalties for Defendants' failure to notify Plaintiff of his right to continued coverage under 29, U.S.C. §1166;

B. Return of health insurance premium paid by Plaintiff to Defendant Conexis following Plaintiff's termination and election of health insurance coverage pursuant to COBRA;

C. $895.50 in damages for healthcare expenses incurred;

D. Reasonable attorney fees;

E. Any other relief this Court deems just and proper.

DATED: November 18, 2014.

PAUL BOROVAC, Plaintiff

BY: 

Justin High #23354
Taylor, High & Younes
661 North 50th St., Suite 200
Omaha, Nebraska 68132
Ph: 402-321-0580
Fax: 402-933-3020
Email: justin@thylaw.com
Attorney for Plaintiff

VERIFICATION

STATE OF NEBRASKA)
)ss
COUNTY OF DOUGLAS)

I, Paul Borovac, do hereby state that I am the Plaintiff in the above-captioned matter, that I have read the foregoing Complaint and attached Exhibits and verify that the contents thereof are true and accurate.

Paul J. Borovac
Paul Borovac

GENERAL NOTARY-State of Nebraska
JUSTIN W HIGH
My Comm. Exp. June 28, 2017

11-18-2014

NATIONAL RAILROAD PASSENGER CORPORATION

AMTRAK

October 11, 2013

File Number: 13-176

Mr. Paul Borovac
P.O. Box 372142
Denver, CO 80237

Mr. Paul Borovac
P.O. Box 1983
Council Bluffs, IA 51502

Dear Mr. Borovac:

Based on the decision of the Hearing Officer David P. Brodar and in consideration of your prior record, you are assessed the following discipline:

- Termination of your employment with the National Railroad Passenger Corporation in all capacities effective immediately.

Please arrange to return all company-issued materials, including your rail travel privilege card to:

Mr. Patrick Sullivan
1003 S. 9th Street
Omaha, Nebraska 68108
Cell Phone: 402-490-7691

Sincerely,

Morrell Savoy
Deputy General Manager, Central Long Distance Service

cc: J. Morris
P. Sullivan
V. Giulian
Human Capital
K. Edelmaier - FED EX #7968 9213 5820
kedelmaier@gmail.com
J. Seegmiller FED EX #7968 9211 2211
utulocal166@aol.com

Paul J. Borovac — Oct 12, 2013

Received and Signed by: Paul Borovac — Date:

EXHIBIT 1

CONEXIS
P.O. Box 226101
Dallas, TX 75222-6101

Date: 6/16/2014
Form: CLC02-CXHEN
Doc ID: 1834642
Account #: 0501108388

To Paul J Borovac and Covered Dependents
PO BOX 1983
COUNCIL BLUFFS IA 51502-1983

COBRA CONTINUATION COVERAGE ELECTION NOTICE

Participant Name: Paul J Borovac
Employer: Amtrak
Election Deadline: 8/18/2014
Qualifying Event: Termination

Date of Notice: 6/16/2014
†Date of Coverage Loss: 2/28/2014
‡COBRA Coverage Start Date if Elected: 3/1/2014

To Paul J Borovac, Covered Spouse, and Covered Dependent Children ofPaul J Borovac, 1108388:

This notice contains important information about your right to continue your health care coverage in the Amtrak group health plan ("Plan") under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace ("Marketplace").

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Please read the information contained in this notice very carefully and keep it for your records. This notice applies equally to each qualified beneficiary identified in this notice.

CONEXIS has been retained by Amtrak to notify you, your covered spouse, and/or your covered dependent children ("Qualified Beneficiaries") of your rights to a temporary extension of group health plan coverage ("COBRA coverage") at group rates after certain events ("qualifying events") that would otherwise cause you to lose coverage under the Plan. NOTE: Notices are sent to the last known address on file with your plan sponsor. It is your obligation to notify Amtrak in writing if there are any Qualified Beneficiaries who reside at a different address. Otherwise they may not receive notice of their rights and obligations under COBRA.

Please use the enclosed COBRA Continuation Coverage Election Form to notify us of your decision to elect COBRA coverage and submit it to CONEXIS in accordance with the COBRA Continuation Coverage Election Form Instructions attached to this letter. NOTE: The form must be submitted by the Election Deadline identified above. If you need further information about COBRA coverage, please contact CONEXIS toll-free at 1-866-206-5751.

If you do not elect COBRA coverage, your coverage under the Plan will end as of 02/28/2014 due to the qualifying event designated above.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. In addition, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

EXHIBIT 2

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You do not have to send any premium payment(s) with the COBRA Continuation Coverage Election Form. Important additional information about payment for COBRA coverage is included in the pages following the COBRA Continuation Coverage Election Form (see "Important Information Concerning Your COBRA Coverage Rights" [below]).

Questions concerning your Plan should be addressed to Amtrak.

If you have any questions about this notice or need further information about your rights to elect COBRA coverage, please contact CONEXIS at 1-866-206-5751.

Amtrak wants to make you aware that you can continue your Group Life and AD&D insurance coverage that you had as an active Amtrak employee. You can do this through either the Portability Option or the Conversion Privilege.

The Portability Option allows you to continue the same or lesser amount of Life or AD&D Insurance coverage that you had on yourself and your dependents at the time of your termination from Amtrak employment. A medical examination may be required under the Portability Option. If you are interested in continuing your coverage with the Portability Option, please call MetLife toll free at 1-888-252-3607 to obtain the rates and an application and start the process.

The Conversion Privilege allows you to convert the coverage you had as an active employee to an individual insurance policy, which will be issued without a medical examination, if you apply for it and pay the required premium within the application period. Generally, you have 31 days from employment termination to convert your coverage. If you are interested in converting to an individual policy contact MetLife Conversion department at 1-877-275-6387.

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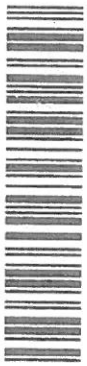

†See below for individual plan termination dates
‡See below for individual plan continuation start dates

COBRA CONTINUATION COVERAGE ELECTION FORM INSTRUCTIONS

Please read the important information about your rights included in the pages following the COBRA Continuation Coverage Election Form (see "Important Information Concerning Your COBRA Coverage Rights") for more information on your rights and obligations under COBRA.

Please complete the attached COBRA Continuation Coverage Election Form and mail the completed COBRA Continuation Coverage Election Form by United States Postal Service ("USPS") to CONEXIS at the following address:

P.O.Box 660453 Dallas, Texas 75266-0453

IF YOU WANT TO ELECT ONLINE: If you wish to elect online, you can complete your enrollment on our Web site at mybenefits.conexis.com. You will need to provide your name, date of birth, valid e-mail address, and Social Security number or your designated CONEXIS account number to register for a CONEXIS "user name." The information you provide in connection with your online enrollment is kept confidential in accordance with CONEXIS' privacy policy, which you can find at mybenefits.conexis.com.

Oral elections will not be accepted. Elections must be made in accordance with these COBRA Continuation Coverage Election Form Instructions.

Your election must be made on or before the Election Deadline identified on the first page of the notice, which is 8/18/2014. If you mail your election to CONEXIS, your completed COBRA Continuation Coverage Election Form must be postmarked by the United States Postal Service (USPS) on or before 8/18/2014. If CONEXIS does not receive the COBRA Continuation Coverage Election Form, you will be responsible for proving that you mailed the election form by the Election Deadline. You may follow up with CONEXIS several days after you have mailed the form to ensure that CONEXIS received it. If you elect COBRA coverage online, you must make your election at the Web site specified above and successfully submitted in accordance with the online instructions on or before 8/18/2014.

If you do not mail or electronically submit a completed COBRA Continuation Coverage Election Form by the Election Deadline shown above, you will lose your right to elect COBRA coverage. If you affirmatively waive your right to COBRA coverage before the Election Deadline, you may revoke the waiver by submitting a completed COBRA Continuation Coverage Election Form in accordance with the instructions above before the original Election Deadline, which is 8/18/2014. However, if you waive COBRA and then later revoke that waiver, your COBRA coverage may not begin until the date that the revocation of your waiver is made, instead of the qualifying event date, which means you would have a gap in coverage.

COBRA CONTINUATION COVERAGE ELECTION FORM

Participant Name: Paul J Borovac
Employer: Amtrak
Form Number: CLC02

Election Deadline: 8/18/2014
Account Number: 0501108388
Document ID: 1834642

Section A1. Group Health Plan Components

Place an "X" in the box adjacent to the monthly cost of the group health plan components(s) you are selecting. Please note that you may not obtain coverage above that which was in effect on your Date of Coverage Loss.

	Date of Group Health Coverage Component Loss	COBRA Coverage Start Date if Electing*
Medical w/ Prescription - Aetna Network Plan Employee Only ☐ $ 771.67	02/28/2014	03/01/2014
Vision - EyeMed Vision Plan DP Employee Only ☐ $ 3.30	02/28/2014	03/01/2014

*Unless you affirmatively waive coverage and then later revoke that coverage.

Section B. Participant Information

Please verify our records are accurate and make changes as necessary. You MUST select the plan type for each individual identified below that you intend to cover. If you need additional COBRA Continuation Coverage Election Forms, please contact CONEXIS at 1-866-206-5751 or you can go to **mybenefits.conexis.com**.

Participant Name		Relationship	Birth Date	Gender
Borovac, Paul J		Self	2/10/1951	M
Medical w/ Prescription ☐	Vision ☐			

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Section C. Medicare Entitlement

Is the covered employee enrolled in Medicare Part A, Part B, or both? ☐ Yes ☐ No

If yes, please provide the enrollment date, as shown on the Medicare card: _____

Applicant's Authorization and Agreement

By my signature below, I:

- elect COBRA continuation of the group health plan component(s) checked in Section A1 under the Amtrak group health plan;
- understand that any COBRA election I make above is deemed to include an election for all other qualified beneficiaries identified above except as specified otherwise above; and
- attest that I have read and understand the information provided to me in this COBRA Continuation Coverage Election Notice, COBRA Continuation Coverage Election Form, and "Important Information Concerning Your COBRA Coverage Rights" enclosure.

Participant Signature: _____ Date: _____

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IMPORTANT INFORMATION CONCERNING YOUR COBRA COVERAGE RIGHTS

COBRA COVERAGE

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a qualifying event (described below). After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to individuals who lose Plan coverage and are qualified beneficiaries.

A qualified beneficiary is any of the following who is covered under the Plan on the day before a qualifying event: (1) the employee or former employee ("covered employee"), (2) the employee's spouse ("covered spouse"), and/or (3) a "child" of the employee, as defined by the Plan ("covered dependent child"). In addition, a child born to, adopted by, or placed for adoption with a covered employee during a period the covered employee's COBRA coverage is considered a qualified beneficiary to the extent that such child is enrolled in accordance with the terms of the Plan. A child of the covered employee receiving benefits pursuant to a qualified medical child support order (QMCSO), to the extent that such child is enrolled in accordance with the terms of the Plan, is entitled to the same rights to elect COBRA coverage as any other covered dependent child.

COBRA coverage is generally the same coverage provided under the Plan to similarly situated active individuals who are not on COBRA. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other similarly situated non-COBRA participants covered under the group health plan component(s) of the Plan elected by the qualified beneficiary, including annual enrollment and special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) generally applies only to the group health plan benefits offered under the Plan and not to any other benefits (e.g., life insurance, disability insurance).

QUALIFYING EVENTS

For covered employees, you may elect COBRA coverage if you lose coverage under the Plan because of either one of the following qualifying events: (1) your hours of employment are reduced; or (2) your employment ends for any reason (other than gross misconduct on your part).

For the covered spouse, you may elect COBRA coverage if you lose coverage under the Plan because of any of the following qualifying events: (1) the covered employee's hours of employment are reduced; (2) the covered employee's employment ends for any reason (other than his or her gross misconduct); (3) the covered employee dies; (4) the covered employee becomes entitled to Medicare benefits under Part A, Part B, or both; or (5) you and the covered employee divorce or legally separate. Also, if the covered spouse's coverage is reduced or dropped by the covered employee in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the spouse even though the coverage was canceled or reduced before the divorce or legal separation. If the ex-spouse notifies the Plan Administrator within 60 days after the divorce and the Plan Administrator determines, in its sole discretion based on the applicable facts and circumstances, that the coverage was dropped in anticipation of the divorce, then COBRA coverage may be available beginning with the date of the divorce (if properly elected).

For a covered dependent child, you may elect COBRA coverage if you lose coverage under the Plan because of any of the following qualifying events: (1) the covered employee's hours of employment are reduced; (2) the covered employee's employment ends for any reason (other than his or her gross misconduct); (3) the covered employee dies; (4) the covered employee becomes entitled to Medicare benefits under Part A, Part B, or both; (5) the covered employee and his or her spouse divorce or legally separate; or (6) you cease to be eligible for coverage under the Plan as a dependent.

You also have a right to elect COBRA coverage if you are covered under the Plan as a retired employee, a covered spouse of a retired employee, the surviving spouse of a retired employee, or a covered dependent child of a retired employee, and lose retiree coverage within one year before or after the commencement of proceedings under Title 11 (bankruptcy), United States Code.

ELECTING COBRA COVERAGE

To elect COBRA coverage, you must complete the COBRA Continuation Coverage Election Form and submit it to CONEXIS according to the instructions included on the COBRA Continuation Coverage Election Form by the date specified on the COBRA Continuation Coverage Election Form. **Failure to do so will result in a loss of the right to elect COBRA coverage under the Plan.** It is recommended that you retain a copy of your COBRA coverage election and any documentation substantiating your submission for your records. Each qualified beneficiary has an independent right to make a COBRA election. That means
that a covered employee and a covered spouse (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. However, a covered employee may not decline COBRA coverage for a covered spouse or an adult covered dependent child (if the spouse or adult covered dependent child is a qualified beneficiary). If the covered employee does not elect coverage for the qualified beneficiary spouse, the qualified beneficiary spouse may elect COBRA coverage separately on behalf of the covered spouse and all other qualified beneficiaries. In addition, the parent or legal guardian of a minor covered dependent child who is a qualified beneficiary may elect coverage on behalf of the minor child.

Additional information about the group health plan component(s) of the Plan is available in the Plan's summary plan description (SPD). If you do not have a copy of the SPD, you may obtain one from the Plan Administrator of your group health plan.

Qualified beneficiaries who are entitled to elect COBRA coverage may do so even if they have other group health plan coverage or are entitled to

Medicare benefits (under Part A, Part B, or both) on or before the date on which COBRA coverage is elected. However, a qualified beneficiary's COBRA coverage may terminate if, after electing COBRA coverage, he or she becomes entitled to Medicare benefits (under Part A, Part B, or both) or covered under other group health plan coverage (see "Duration of COBRA Coverage" below for more information on when COBRA coverage ends).

When considering whether to elect COBRA coverage, you should consider that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above. You will also have the same special enrollment right after you exhaust the maximum COBRA coverage period available to you.

DURATION OF COBRA COVERAGE

The maximum COBRA period is generally measured from the date of the qualifying event, even if coverage is not immediately lost (unless stated otherwise in your SPD). COBRA coverage begins on the day following the date that coverage under the Plan is lost because of the qualifying event.

In the case of a loss of coverage due to the covered employee's termination of employment or reduction in hours of the covered employee's employment, coverage may generally last for up to 18 months.

When the qualifying event is the covered employee's termination of employment or reduction in hours of the covered employee's employment, and the employee became entitled to Medicare benefits (under Part A, Part B, or both) less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the termination of employment or reduction in hours qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which her employment terminates, COBRA coverage for her spouse and children who lost coverage as a result of her termination of employment can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). If you were already entitled to Medicare before electing COBRA, please notify CONEXIS of the date of your Medicare entitlement according to CONEXIS notice procedures (see "Notice Procedures for Qualified Beneficiaries" [below]).

In the case of a loss of coverage due to the death of the employee, the covered employee's divorce or legal separation, the covered employee's becoming enrolled in Medicare benefits (under Part A, Part B, or both), or a covered child losing eligibility as a child under the terms of the Plan, COBRA coverage may last for up to 36 months (provided that timely notice of the qualifying event was provided in accordance with the Plan's notice procedures).

COBRA coverage under a Health FSA may only last through the end of the plan year in which the qualifying event occurs (unless stated otherwise in the group health plan SPD). This coverage may not be extended beyond the end of the plan year (see "Special Health FSA Rule" [below]), except for a grace period applicable to the plan year.

The COBRA periods described above are maximum coverage periods. The law provides that COBRA coverage may be terminated prior to the end of the maximum coverage periods described in this notice for any of the following reasons: (1) the employer/former employer no longer provides any group health coverage to any of its employees; (2) the premium for COBRA coverage is not paid in a timely manner; (3) you first become, after electing COBRA coverage, covered under any other group health plan (as a covered employee or otherwise) which does not contain any applicable exclusion or limitation with respect to any preexisting condition (NOTE: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited starting with plan years that begin in 2014); (4) you first become, after electing COBRA coverage, entitled to Medicare benefits (under Part A, Part B, or both); or (5) during a disability extension period (see "Disability Extension of COBRA Coverage" [below]), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify CONEXIS in writing as soon as possible within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under other group health plan coverage or becomes enrolled in Medicare benefits (under Part A, Part B, or both) according to CONEXIS notice procedures (see "Notice Procedures for Qualified Beneficiaries" [below]).

Special Health FSA Rule

If you have coverage under a Health FSA that is an excepted benefit (as defined by HIPAA's portability rules), you may only continue coverage through the end of the plan year in which the qualifying event occurs (unless stated otherwise in the group health plan SPD), except for a grace period applicable to the plan year.

Moreover, only those who have "underspent" their account as of the date of the qualifying event may elect Health FSA coverage. A qualified beneficiary has an "underspent" account if the account balance at the time of the qualifying event is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (that is, the elected annual limit reduced by reimbursable claims submitted up to the time of the qualifying event). The "use-it-or-lose-it" rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the plan year (unless stated otherwise in the group health plan SPD), subject to any applicable grace period attributable to the plan year.

Special Rules for Leaves of Absence Due to Services in the Uniformed Services

If a covered employee takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Act [USERRA]) that is expected to last 31 days or more, the covered employee may be able to continue health coverage for the employee and any covered dependents until the earlier of 24 months from the date the leave began or the date that the employee fails to return to or apply for work as required under USERRA. The cost to continue this coverage during the 24-month period is 102 percent of the applicable premium. The USERRA continuation period will run concurrent with the COBRA period described herein, unless specified otherwise in the SPD. The rights described in this notice apply only to the COBRA continuation period. Notwithstanding anything to the contrary in this notice, continuation of coverage under a military leave of absence covered under USERRA will be administered in accordance with the requirements of USERRA.

Extending the Duration of COBRA Coverage

If you elect COBRA coverage resulting from a covered employee's termination of employment or reduction in hours of the covered employee's employment, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify CONEXIS of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event may eliminate the right to extend the period of COBRA coverage. The determination is at the sole discretion of the Plan Administrator. (The period of COBRA coverage under a Health FSA cannot be extended [unless stated otherwise in the group health plan SPD].)

Disability Extension of COBRA Coverage

If you or any qualified beneficiary in your family is determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act, the maximum COBRA coverage period that results from a covered employee's termination of employment or reduction in hours of the covered employee's employment (generally 18 months, as described above) may be extended for an additional 11 months of COBRA coverage (for a total of 29 months). This disability must have started at some time prior to or within the first 60 days of the COBRA continuation period arising from a qualifying event that is a termination of employment or reduction in hours of employment and must last at least until the end of the period of COBRA coverage that would otherwise be available without the disability extension (generally 18 months, as described above).

While the Social Security Administration offices in each state vary and do not always provide the same "Social Security Administration Retirement, Survivors and Disability Insurance Notice of Award" letter, many such award letters list this disability start date under the heading "The Date You Became Disabled." For example, if you receive a Social Security Administration award letter that reads, "We found that you became disabled under our rules on January 15, 2002," the disability start date for this purpose would be January 15, 2002.

Each qualified beneficiary in your family who has elected COBRA coverage due to the same qualifying event as the disabled qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify CONEXIS according to CONEXIS notice procedures (see "Notice Procedures for Qualified Beneficiaries" [below]) of the Social Security Administration's determination of disability within 60 days after the latest of: (1) the date of the determination of disability by the Social Security Administration; (2) the date of the qualifying event that is the covered employee's termination of employment or reduction in hours of the covered employee's employment; or (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the covered employee's termination of employment or reduction in hours of the covered employee's employment. In addition, you must also provide notice of the Social Security Administration's determination of disability prior to the end of the 18-month continuation period (regardless of when the 60-day period would otherwise end).

If these procedures are not followed or if the notice is not provided during the applicable notice period, then you may be determined to be ineligible to receive the disability extension of COBRA coverage. This determination is at the sole discretion of the Plan Administrator.

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify CONEXIS of that fact as soon as possible but no later than 30 days after the Social Security Administration's final determination according to CONEXIS notice procedures (see "Notice Procedures for Qualified Beneficiaries" [below]). If COBRA coverage is extended due solely to the disability, extended COBRA coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration's notice that the qualified beneficiary is no longer disabled or the end of the maximum COBRA period, whichever is earlier.

Second Qualifying Event Extension of COBRA Coverage

If a qualified beneficiary who is a covered spouse or covered dependent child experiences another qualifying event during the first 18 months of COBRA coverage (because of the covered employee's termination of employment or reduction in hours of the covered employee's employment) or during an 11-month disability extension period (see "Disability Extension of COBRA Coverage" [above]), this qualified beneficiary receiving COBRA coverage may receive up to 18 additional months of COBRA coverage (for a total of 36 months), if notice of the second qualifying event is provided in accordance with CONEXIS notice procedures (see "Notice Procedures for Qualified Beneficiaries" [below])

This extension may be available to the covered spouse and any covered dependent children receiving COBRA coverage if the employee/former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the covered dependent child stops being eligible under the Plan as a "dependent child," but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (A second event will be a "second qualifying event" for COBRA purposes only to the extent that it would have caused the qualified beneficiary to lose coverage under the Plan had it been the initial qualifying event.)

This second qualifying event extension is available only if you notify CONEXIS according to CONEXIS' notice procedures (see "Notice Procedures for Qualified Beneficiaries" below) of the second qualifying event within 60 days after the date of the second qualifying event occurs.

If you do not follow CONEXIS notice procedures, then you will not be eligible for the extension of coverage.

COST OF COBRA COVERAGE

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The current required monthly payment for each group health plan component of the Plan under which you are entitled to elect COBRA coverage is shown on the COBRA Continuation Coverage Election Form. Note that these amounts are subject to change in the future in accordance with the Plan's provisions and will most likely be higher than they are now.

PAYING FOR COBRA COVERAGE

INITIAL PREMIUM PAYMENT

If you elect COBRA coverage, you are not required to send any payment with the COBRA Continuation Coverage Election Form. However, you must make your initial payment for COBRA coverage not later than 45 days after the date of your election. The "date of your election" is the date on which your completed COBRA Continuation Coverage Election Form is postmarked by the USPS, if mailed, or the date on which your COBRA election is successfully submitted electronically if made at the Web site specified above. If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your initial premium payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month preceding the month in which your payment is made. For example, a June 1 election, based on an April 30 qualifying event and loss of coverage under the Plan, would require an initial premium payment equaling the premiums for May and June and is due on or before July 15, the 45th day after the COBRA coverage election. You are responsible for ensuring that the amount of your initial payment is enough to cover this entire period. You may contact CONEXIS to confirm the correct amount of your initial premium payment.

Claims for benefits may not be processed and paid until after you have elected COBRA coverage and paid required premiums.

MONTHLY PREMIUM PAYMENTS

After you make your initial premium payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary is shown on the COBRA Continuation Coverage Election Form. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. You may receive a courtesy monthly invoice within two weeks of your COBRA coverage election. You may also receive courtesy monthly invoices for each subsequent period thereafter, assuming your COBRA coverage has not been canceled. **However, you are responsible for paying the full premium on time even if you do not receive an invoice.**

GRACE PERIODS FOR MONTHLY PREMIUM PAYMENTS

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

IMPORTANT: If you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan may be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claims for benefits you submit for benefits while coverage is suspended may not be processed and paid until after you have timely paid the full premium. CONEXIS will not request an update of eligibility for any qualified beneficiary until the monthly premium due is received and applied. Depending upon the timing of receipt of a premium payment, it may take several days to process and update eligibility with the insurance carrier.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan and your coverage will end as of the last day of the last month for which you made a full and timely premium payment.

Your courtesy monthly invoices will provide a remittance address and indicate the amount owed and due date. This invoice should be signed, detached, and enclosed with each month's premium payment. If mailed, your payment is considered to have been made on the date that it is USPS postmarked provided that it is ultimately received by CONEXIS. CONEXIS is a third-party administrator and is not engaged in the provision of health care benefits. Any deposit of a payment by CONEXIS prior to return of such money will not constitute an acceptance of the premium payment. Depending on the timing of receipt of payment and scheduled communication updates, it may take several days to update eligibility with your group health insurance carrier(s). Waiting until the end of the grace period to make your payment could also put you at risk of not having sufficient time to correct errors. You will not be considered to have made any payment if your payment is returned due to insufficient funds or if there is otherwise a discrepancy with your payment (e.g., funds are not immediately available or verifiable, invalid banking account number, unsigned checks, incorrect payment amounts, payments sent to the wrong address, late or missed pickups by the USPS) and your account for that period will be marked as unpaid. CONEXIS cannot guarantee that you will be notified of the discrepancy in time to correct your payment prior to the end of any applicable grace period. In such event, you will lose all rights to COBRA coverage under the Plan. In the event that the employer or plan sponsor terminates the Plan (through voluntary termination or bankruptcy) your group health coverage may be terminated retroactively. In the event that the Plan is terminated, CONEXIS cannot guarantee a refund of your payment if CONEXIS has already forwarded that payment to the employer or plan sponsor for payment on your behalf.

NOTICE PROCEDURES FOR QUALIFIED BENEFICIARIES

IMPORTANT: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries may lose the right to any extension of COBRA coverage.

Any required notice the qualified beneficiary is required to furnish (as described above) must follow these notices procedures. Notices must be sent to CONEXIS in writing (by mail or electronic transmittal [e.g., e-mail]) to:

CONEXIS P.O.Box 660453 Dallas, Texas 75266-0453
customerdelivery@conexis.com

If a different address and/or procedures for providing notices to the Plan appear in the Plan's most recent SPD, you must follow those notice procedures or deliver your notice to that address.

Oral notice (including notice by telephone) is not acceptable.

Any notice you provide must contain the name of the Plan (Amtrak group health plan); the name, CONEXIS Account Number or Social Security number, and address of the employee/former employee who is or was covered under the Plan; the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; and the certification, signature, name, address, and telephone number of the person providing the notice.

The employee/former employee who is or was covered under the Plan, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide the notices described herein. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

ADDITIONAL NOTICE PROCEDURES FOR A NOTICE OF DISABILITY

A Notice of Disability must also contain the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the initial qualifying event and who are currently receiving COBRA coverage at the time the Notice of Disability is provided; the name and address of the disabled qualified beneficiary as determined by the Social Security Administration; the date that the qualified beneficiary became disabled as determined by the Social Security Administration; the date that the Social Security Administration made its determination of disability (generally, this is the date on which the "Social Security Administration Retirement, Survivors and Disability Insurance Notice of Award" letter was issued); and a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled. A copy of the "Social Security Administration Retirement, Survivors and Disability Insurance Notice of Award" letter should be included (or any other substantiating documentation provided to you by the Social Security Administration that discloses the date on which you became disabled and the date on which the Social Security Administration made such determination).

If you provide a written notice to CONEXIS that does not contain all of the information and documentation specified by these Notice Procedures and Additional Notice Procedures for a Notice of Disability, such a notice will be considered sufficient if it is mailed or transmitted electronically to CONEXIS at the address, facsimile number, or e-mail address specified above or provided directly to the Plan Administrator according to the notice procedures appearing in the Plan's most recent SPD; the notice is provided by the deadline specified above; and the notice is substantiated with any additional information and documentation as the Plan and/or CONEXIS deems necessary to meet these requirements (as described in these Notice Procedures for a Notice of Disability) within 10 business days after a written request from CONEXIS or the Plan for more information (or, if later, by the deadline for the Notice of Disability described above).

If these procedures are not followed or if the notice is not provided during the applicable 60-day notice period and within 18 months after the covered employee's termination of employment or reduction in hours of the covered employee's employment, then you may be determined to be ineligible to receive the disability extension of COBRA coverage. This determination is at the sole discretion of the Plan Administrator.

ADDITIONAL NOTICE PROCEDURES FOR A NOTICE OF A SECOND QUALIFYING EVENT

A Notice of a Second Qualifying Event must also contain the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the initial qualifying event and are currently receiving COBRA coverage at the time the Notice of a Second Qualifying Event is provided; the second qualifying event (i.e., the employee/former employee dies, becomes entitled to Medicare benefits [under Part A, Part B, or both], or gets divorced or legally separated, or if the covered child stops being eligible under the Plan as a child); and the date that the second qualifying event occurred.

If the Notice of a Second Qualifying Event relates to the death of the employee/former employee, you must, if requested, provide additional satisfactory documentation of the date of death (e.g., a death certificate).

If the Notice of a Second Qualifying Event relates to the entitlement to Medicare benefits (under Part A, Part B, or both) of the employee/former employee, your notice must include the date that Medicare entitlement occurred and a copy of the Medicare card showing the date of Medicare entitlement. (Typically, a covered employee's entitlement to Medicare benefits [under Part A, Part B, or both] will not be a qualifying event for spouses or covered children of active employees due to the Medicare Secondary Payer rules; in such a case, this extension is not available under the Plan when an employee/former employee becomes entitled to Medicare benefits after his or her termination of employment or reduction in hours of employment.)

If the Notice of a Second Qualifying Event relates to a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If the Notice of a Second Qualifying Event relates to a covered child's loss of eligibility under the Plan as a child, you must, if requested, provide additional satisfactory documentation of the date on which this loss of eligibility occurred (e.g., a birth certificate establishing the child's age).

If you provide a written notice to CONEXIS that does not contain all the information and documentation specified in these Notice Procedures and Additional Notice Procedures for a Notice of a Second Qualifying Event, such a notice will be considered sufficient if it is mailed or transmitted electronically to CONEXIS at the address, facsimile number, or e-mail address specified above or provided directly to the Plan Administrator according to the notice procedures appearing in the Plan's most recent SPD; the notice is provided by the deadline specified above; and the notice is substantiated with any additional information and documentation as the Plan and/or CONEXIS deems necessary to meet these requirements (as described in these Notice Procedures for a Notice of a Second Qualifying Event) within 10 business days after a written request from CONEXIS or the Plan for more information (or, if later, by the deadline for the Notice of a Second Qualifying Event described above).

If these procedures are not followed or if the notice is not provided during the applicable 60-day notice period, then you may be determined to be ineligible to receive the second qualifying event extension of COBRA coverage. This determination is at the sole discretion of the Plan Administrator.

ADDITIONAL NOTICE PROCEDURES FOR A NOTICE OF OTHER GROUP HEALTH PLAN COVERAGE OR MEDICARE ENTITLEMENT

A Notice of Other Group Health Plan Coverage or Medicare Entitlement must contain the name of the Plan (Amtrak group health plan); the name, CONEXIS Account Number or Social Security number, and address of the employee or former employee who is or was covered under the Plan; the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the initial qualifying event and who are currently receiving COBRA coverage at the time the Notice of Other Group Health Plan Coverage or Medicare Entitlement is provided; the name and address of the qualified beneficiary(ies) who obtained other coverage or became entitled to Medicare benefits (under Part A, Part B, or both); the date the other coverage became effective; if applicable, the date that any preexisting condition exclusions applicable to the qualified beneficiary(ies) were exhausted or satisfied; and evidence of the effective date of other group health plan coverage (e.g., a copy of the insurance card) or the date Medicare entitlement occurred (e.g., a copy of the Medicare card showing the date of Medicare entitlement).

If a qualified beneficiary becomes, after electing COBRA coverage, covered under other group health plan coverage or entitled to Medicare benefits (under Part A, Part B, or both), that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) regardless of whether or when Notice of Other Group Health Plan Coverage or Medicare Entitlement is provided. Amtrak may require repayment to the Plan of all benefits paid after the COBRA coverage termination date.

ADDITIONAL NOTICE PROCEDURES FOR REQUESTS FOR CANCELLATION OF COBRA COVERAGE

If you are currently receiving COBRA coverage for which a premium has yet to be paid and wish to cancel your further COBRA coverage, you may refrain from paying the COBRA premium for the coverage period that begins when you no longer want COBRA coverage. For example, if a qualified beneficiary is receiving COBRA coverage, has paid premiums through December 31, and wishes to cancel further COBRA coverage effective January 1, the qualified beneficiary would simply not pay the premium for the January coverage period. If the January premium is not paid by the expiration of the applicable grace period (e.g., January 31), the qualified beneficiary's COBRA coverage would cancel automatically on December 31.

ADDITIONAL NOTICE PROCEDURES FOR A NOTICE OF CHANGE OF ADDRESS

To protect your and your family's rights, it is important that you keep CONEXIS informed of the current addresses of all qualified beneficiaries under the Plan. You should also keep a copy, for your records, of any notices you send to the Plan Administrator and/or CONEXIS.

If your address or the address of a family member changes during a period of COBRA coverage, you must immediately notify CONEXIS in writing following the notice procedures described above.

FOR MORE INFORMATION

This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available to you in your SPD or from the Plan Administrator.

If you have questions about claims for reimbursement, please contact your sponsoring employer, group health insurance carrier or the claims office indicated on your claim forms or insurance card.

For additional information about your COBRA rights and obligations under federal law, please review the Plan's SPD or contact CONEXIS at 1-866-206-5751 or the above address.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Marketplace, visit www.healthcare.gov.

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the U.S. Department of Labor, Office of the Chief Information officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 09/30/2013).

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COBRA CONTINUATION COVERAGE ELECTION FORM

Participant Name: Paul J Borovac
Employer: Amtrak
Form Number: CLC02

Election Deadline: 8/18/2014
Account Number: 0501108388
Document ID: 1834642

Section A1. Group Health Plan Components

Place an "X" in the box adjacent to the monthly cost of the group health plan components(s) you are selecting. Please note that you may not obtain coverage above that which was in effect on your Date of Coverage Loss.

	Date of Group Health Coverage Component Loss	COBRA Coverage Start Date if Electing*
Medical w/ Prescription - Aetna Network Plan Employee Only ☒ $ 771.67	02/28/2014	03/01/2014
Vision - EyeMed Vision Plan DP Employee Only ☒ $ 3.30	02/28/2014	03/01/2014

*Unless you affirmatively waive coverage and then later revoke that coverage.

Section B. Participant Information

Please verify our records are accurate and make changes as necessary. You MUST select the plan type for each individual identified below that you intend to cover. If you need additional COBRA Continuation Coverage Election Forms, please contact CONEXIS at 1-866-206-5751 or you can go to **mybenefits.conexis.com**.

Participant Name		Relationship	Birth Date	Gender
Borovac, Paul J		Self	2/10/1951	M
Medical w/ Prescription ☒	Vision ☒			

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Section C. Medicare Entitlement

Is the covered employee enrolled in Medicare Part A, Part B, or both? ☐ Yes ☒ No

If yes, please provide the enrollment date, as shown on the Medicare card: _____

Applicant's Authorization and Agreement

By my signature below, I:

- elect COBRA continuation of the group health plan component(s) checked in Section A1 under the Amtrak group health plan;
- understand that any COBRA election I make above is deemed to include an election for all other qualified beneficiaries identified above except as specified otherwise above; and
- attest that I have read and understand the information provided to me in this COBRA Continuation Coverage Election Notice, COBRA Continuation Coverage Election Form, and "Important Information Concerning Your COBRA Coverage Rights" enclosure.

Participant Signature: Paul J. Borovac Date: July 25, 2014

EXHIBIT 3